DOCUMENT RESUME

ED 264 021 PS 015 499

AUTHOR Clark, Roberta J.; And Others
TITLE Adolescent-Infant Development: A Family-Centered Approach to Working with Teen Parents and Their High Risk Infants.
SPONS AGENCY Special Education Programs (ED/OSERS), Washington, DC.
PUB DATE Mar 85
GRANT G008303643
NOTE 34p.; Paper presented at the Biennial Meeting of the National Training Institute (4th, Washington, DC, December 6-8, 1985). Tables 2 and 4 contain small print.
PUB TYPE Reports - Descriptive (141) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Adolescent Development; Case Studies; Child Development; *Early Parenthood; Family Influence; Family Role; *High Risk Persons; *Infants; *Mothers; Pregnancy; Program Descriptions
IDENTIFIERS *Adolescent Infant Development Program DC; *Early Intervention Programs; Psychosocial Development

ABSTRACT

Using two cases as the basis of exploration, this article discusses (1) the impact of pregnancy during adolescence on the development of the young girl and her offspring and (2) the influences of her extended family. It also explores the concept of adolescent/infant development as a means of providing comprehensive services to pregnant adolescents, adolescent parents, and their infants. The underlying premise for the concept of adolescent/infant development is that the development of both adolescents and infants must be facilitated. Important features of the model demonstration program developed at Howard University Hospital, designed to implement this premise, are that intervention with adolescent parents begins during pregnancy whenever possible and that follow-up services are provided for 3 years after the birth of the baby. Major emphases of the program includes assisting the adolescent in continuing her education, encouraging her self-sufficiency and independence, and discouraging additional pregnancies during the adolescent period. These goals are achieved by using a holistic, family-centered approach to working with the adolescent parent/infant dyad. Four tables are appended. (Author/RH)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION
CENTER (ERIC)
X This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

ED264021

"Adolescent-Infant Development: A Family-Centered Approach to Working with Teen Parents and their High Risk Infants"

Authors: Roberta J. Clark, Ed.D., Cassandra S. Williams, M.Ed., Bernita B. Smith, M.S.W., Department of Pediatrics and Child Health, Howard University Hospital

Contact Person:

Dr. Roberta J. Clark
Department of Pediatrics and Child Health
Howard University Hospital
2041 Georgia Avenue, N.W.
Washington, D.C. 20060
202/745-1596

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Roberta J. Clark
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

PS 015499

DISCLAIMER

Parts of this work were developed under a grant (Grant No. G008303643) with Special Education Programs, U.S. Department of Education. The content, however, does not necessarily reflect the position or policy of SEP/ED and no official endorsement of these materials should be inferred.

March 1985

ABSTRACT

Teenage pregnancy is a major problem in this country. The literature supports the theory that, in order for the adverse consequences of early childbearing to be minimized, a comprehensive approach is needed. This article discusses the impact of pregnancy during adolescence on the development of the young girl and her offspring and the influences of her extended family. It also explores the concept of adolescent-infant development as a means of providing comprehensive services to pregnant adolescents, adolescent parents and their infants.

The underlying premise behind the concept of adolescent-infant development is that the development of both adolescent and infants must be facilitated. An important feature of the model demonstration program developed at Howard University Hospital, designed to implement this premise, is that intervention with pregnant adolescents begins prenatally whenever possible, and follow-up services are provided for three years after the birth of the baby. A major emphasis of the program includes assisting the adolescent in continuing her education, encouraging her self-sufficiency and independence and discouraging additional pregnancies during the adolescent period. This is done by using a holistic, family-centered approach to working with the adolescent parent-infant dyad.

Two cases will be used to explore problems associated with working with this population and to illustrate the impact of family dynamics on the development of the adolescent parent and her infant.

Key Terms: Adolescent Development

Child Development

Adolescent Pregnancy

Early Intervention

Introduction

It has been well documented that infants born to adolescent mothers are at risk for early mortality, morbidity and various types of handicapping conditions. [1, 2, 3] However, little has been done to address the needs of the adolescent parent and their infant as a unit. The concept of Adolescent-Infant Development implies that the pregnant adolescent or the adolescent parent is a child in her own right and therefore her development is as important as the development of her high risk infant. In fact, the normal development of the parent is essential if appropriate development of the child is to take place.

Adolescent-Infant Development in relation to teen pregnancy is a comprehensive method of providing early intervention to pregnant adolescents and/or adolescent parents and their high risk infants. This method is a family-centered approach used to facilitate appropriate growth and development of both parent and infant to the greatest extent possible. When the term family is used in regards to this approach, it includes the extended family of the adolescent, since in many instances the teen parent is living in the home of her parent(s) and she and her child's behavior is greatly influenced by her parent's beliefs, practices, demands and standard of living. Therefore, if intervention aimed at fostering appropriate development of the teenage mother and her infant is to be successful, it must also include the extended family when they directly influence the mother-infant dyad.

Review of the literature on the subject supports the need for programs which provide comprehensive services for the pregnant adolescent/adolescent

parent and her high risk infant.[4,5,6] Therefore, programs which seek to address the needs of high risk/handicapped infants born to teenage parents must emphasize the development of the young parent as well as the development of the young child.

In October 1983, Howard University was funded to develop a model demonstration project based on the concept of adolescent-infant development. The Adolescent-Infant Development Program (A.I.D.) seeks to identify possible problems which the adolescent mother-infant dyad might encounter, in order to prevent and/or reduce the difficulties related to known risk factors experienced by adolescent parents and their children. One of A.I.D.'s major objectives is to help the adolescent and infant to adapt to their high risk situation by assisting the teenager in developing appropriately as an adolescent and as a mother, and by providing the high risk infant with early developmental/educational intervention. In many cases this goal cannot be accomplished without the involvement of the adolescent's extended family, therefore a family-centered approach must be utilized.

This article will discuss the role of the family in providing comprehensive services to adolescent parents and their infants and its relationship to the concept of adolescent-infant development. Two cases of clients served by the Adolescent-Infant Development Program at Howard University will be used to explore problems associated with working with this population and to illustrate the impact of family dynamics on the development of the adolescent parent and her infant.

Familial Influences on Adolescent Pregnancy and Parenthood

Under the best circumstances, adolescence is a time of uncertainty, confusion and experimentation. Adolescents are trying to find out "who they really are" and are beginning to assert their independence. Peers have a significant influence on their behavior and parental authority is often looked upon with disdain. The diverse values of peers and parents may place the adolescent in conflict, creating a double bind situation where the adolescent feels that he or she will lose no matter which direction they choose. For the pregnant adolescent, the situation is compounded. However, the degree to which they have resolved the conflict between parent, peers and personal independence will play a major role in their ability to cope and make decisions about their pregnancy.

Regardless of whether the adolescent has positive or negative family relationships, her family will influence her decision about her pregnancy in some way. In a study done by Fischman in 1977, examination of factors influencing inner city pregnant girls to abort or deliver indicated that those girls who decided to deliver had greater familial support than those who aborted.[7] Fischman also indicated that for adolescents who decide to carry their pregnancy to term, familial approval played a crucial part in their decision-making process due to the young girl's age and financial dependency.[7] Specific familial influences on adolescent delivery and abortion are depicted in Table 1.

Not only does the family of the adolescent have a significant influence on whether the young girl will carry her pregnancy to term, it also influences

other stages in the girl's life as she proceeds from pregnancy to parenthood if she chooses to go that route. Familial influences may be direct or indirect. In some cases, the family which chooses not to have anything to do with its pregnant adolescent can have a greater impact than a family which is directly trying to influence the young girl's behavior and decisions. Table 2 outlines how familial influences affect adolescents from pregnancy to parenthood in areas such as delivery, education, future professional opportunities, marriage, child rearing practices and fertility.

For the pregnant adolescent and the adolescent parent, family support is essential for their survival and future development. According to the Guttmacher Institute and the Mott Foundation, familial support is one of the major factors which can lessen the negative consequences of early childbearing on adolescents.[1,8] Both organizations reported that those pregnant adolescents and adolescent parents who lived with their families tended to have a more positive future in terms of returning to school, graduating, holding jobs and becoming self sufficient, than those adolescents who lived alone (Table 3). The Mott Foundation also reported that the children born to adolescent parents who lived with their grandparents as well as their mother were more cognitively developed than those children who were only raised by their adolescent mother.[8]

Although it is encouraging that familial support can lessen the adverse outcome of teenage pregnancy, there is a strong indication that this support is diminishing as a result of the cyclical effect of children having children which is currently creating younger and younger grandparents.

In a study done by Ladner of two generations of teenage mothers in Washington, D.C., she found grandparents as young as 29 years old.[9] In

her report, she stated that:

> ...Since some grandmothers are still young women, they, justtifiably, should have the opportunity to enjoy life and not be "saddled down" with not only their own children, but their daughter's child or children as well. In response to these changing conditions, increasingly young grandmothers are no longer bound by traditional sanctions. They are refusing to accept the traditional role of grandmother who acts as the caretaker of the unmarried daughter's children, a phenomenon that is unparalleled in the history of Black people.[9]

Even though many pregnant adolescents still live with their parents, an increasing number of these girls are no longer getting the traditional support from their families that they used to receive (especially in the area of child care). Therefore, teen parents must look outside of their extended family in order to obtain the help they need from other sources. Lack of experience in securing such help hinders the adolescent parent's ability to take advantage of many of the services which are available to her and her child. The young parent's extended family can assist the adolescent in getting outside support. However, the stability of the family as well as the family's overall needs and priorities will play an important part in determining whether the adverse impact of parenthood on the teen is seen as a major area of concern for the family as a whole. If the girl's family realizes how pregnancy can negatively impact on the future development of the adolescent, it will problaby try to assist her in obtaining outside support even if family members are unable to provide it themselves. However, if teenage

pregnancy is seen as a natural occurance in life and is compared to the larger problems the family is currently facing, the teen parent's problems may be of little or no consequence to the family. Under these circumstances, the adolescent parent is left alone trying to find a means of surviving in a system which she is too immature and inexperienced to understand and master.

Psychosocial Development of the Adolescent Parent

Adolescent pregnancy is often viewed in relationship to the medical consequences for mother and child. However, the effects of pregnancy on the psychosocial development of the adolescent is equally important. Adolescence is an important stage in ones life because it provides the vehicle for one to pass from childhood to adulthood. In order for one to make a successful transition from childhood to adulthood, there are four major tasks which one must achieve. According to Irwin, these tasks are as follows:

1. To establish a stable identity.
2. To accept his/her sexuality and adjust to his/her adult sexual role.
3. To establish independence from the family.
4. To make a career or vocational choice.[10]

If the adolescent does not achieve one of these tasks for some reason then her development is impaired as is her future ability to function as an adult. The point of interruption of the adolescent's development will determine the extent to which development is impeded and the severity of the consequences manifested in later adult life. The period of adolescence ranges from about age 10-20 for famales and from about age 12-20 for males. However, within this period there are three developmental stages which one passes through--early, middle and late. Table 4 further illuminates the developmental process which takes place during the three stages of adolescence.

What occurs when an adolescent's development is interrupted by pregnancy largely depends on which developmental stage the girl is in when the

pregnancy takes place. The farther along the developmental continuum the girl is, the less medical complications the girl will probably experience and the better the girl will probably be able to cope socially and emotionally with the pregnancy. (Although approximate ages are given for when individuals generally pass through each stage of adolescence, it is important to remember that everyone is different and that some girls may go through a stage faster or slower than the average. Also, it is important to keep in mind that one does not always develop uniformly in all areas. For example, a girl may be physically in late adolescence, but may be emotionally still in early or middle adolescence.)

Adolescent girls who become pregnant during the early (10-13 years old) or middle stage (13-16 years) of the adolescent period are more likely to have low birth weight babies. According to Ladner, these girls are also considered high risk because of their immature body stature and gynecological development.[9] She also states that their emotional immaturity prevents them from seeking health care and following medical advice until the second trimester of pregnancy and sometimes even later which jeopardizes both the adolescent's health and that of her baby.[9] Many adolescents also deny their pregnancy during this period, fearing reprisal and ostracism from their families.

The most far-reaching effect of pregnancy during any of the periods of adolescent development is that there is an interruption of education which ultimately limits their future job opportunities. Also, with little education, these adolescent mothers are unable to provide the kind of stimulation and nurturing that their young child will need.[9]

In terms of developmental issues, an adolescent who becomes pregnant

at any stage during the adolescent development period is generally unable to complete the necessary developmental tasks of that period. Due to her lack of education and/or skills, this prevents the adolescent from gaining independence from her family. It is also somewhat difficult to establish one's identity when one has to care for and be responsible for the development, survival and very existence of another human being unless one has adequate external support and resources. Additionally, adolescent social development is thwarted since opportunity to develop peer relationships are limited.

According to Johnson, nine months is not enough time for an adolescent to complete her personal development and also obtain the skills needed for motherhood.[6] However, adequate personal development is essential for appropriate parenting skills to take place. Without such development, the adolescent parent will use her infant as a means of fulfilling her own unmet needs rather than trying to fulfill the needs of her infant. Therefore, programs which seek to serve this population need to emphasize development on three levels. These areas of development are:

a) Development of appropriate adolescent behavior, forming the necessary prerequisites for passage into adulthood.

b) Development of parenting skills.

c) Infant development.

In order to construct an effective Adolescent-Infant Development program for pregnant adolescents and their offspring, the literature suggests that a comprehensive family-centered approach is a key element.[4,11] A family-centered approach is important for the development of the pregnant adolescent, since findings suggest that the type of interactions these girls

have with their mothers (caregivers) determines their advance towards autonomy, cognitive development and ability to integrate thinking and experiences, enabling them to enter womanhood.[12] Any disturbances in these interactions can lead to impaired adolescent development.[12] As previously discussed, a family-centered approach is necessary since the adolescent's family will impact upon the teen mother and her baby from pregnancy through parenthood.

The Development of Infants Born to Adolescent Parents

Since adolescent pregnancy has reached epidemic proportions in this country, it has become more and more accepted that the offspring of teen parents are at a greater risk than those infants born to older parents.[13] There has been much discussion and some disagreement about why infants born to teen parents are at risk but statistics clearly indicate that the following risk factors exist for this population of infants:

-Increased incidence of low birth weight.

-Increased incidence of prematurity.

-Increased morbidity and mortality.

-Increased incidence of intrauterine growth retardation.

-Higher incidence of serious health problems.

-Decreased I.Q. scores.

The major problems for infants born to teen parents are prematurity and low birth weight (LBW) because these conditions indicate that the neonate was born before all of his physiologic and metabolic systems were fully developed.[2] As a result, the small infant who was born much too early and weighs so little has greater difficulty fighting common infections found in his environment and he must struggle to maintain his very existence. In some cases, this struggle is more than the LBW/premature infant's fragile and underdeveloped body can handle. Spivack describes those infants of teen parents who are born prematurely and/or have a variety of medical conditions as "At-definite risk infants." These infants are at-definite risk since their problems compound the already stressed social-emotional state of the adolescent parent.[14] Spivack goes on to say that these young mothers are often unable to take care of their own needs and the extra needs of an infant

with medical complications may be too overwhelming for them to cope with.[14] Such medical conditions can severely impede normal bonding and may negatively impact on the teenage mother-infant relationship. Donlen and Lynch noted that in such cases "just when the young mother is most likely to be receptive and responsive to her newborn, he's removed to a specialized unit or perhaps even a distant hospital."[2]

Despite the fact that medical complications of infants born to teen parents may inhibit the development of normal maternal-infant relationships, adolescent parents can be taught to appropriately interact with their high-risk baby. Although the bonding process of the high risk infants may be interrupted by immediate separation isolettes, life support systems and extended hospitalization, and may cause the adolescent to have feelings of shame, guilt and inadequacy, it is important to encourage the young mother (and father, if he is known and available) to visit, touch and interact with the baby as much as is medically permitted, as soon as possible.

Early interaction will aid the young parent in adjusting to her new baby and his condition.[15] The young parents of high risk infants need to be educated in understanding their child's medical condition and how they can best help their child reach his full potential. The young parent also needs reassurance and should be taught how to competently interact with her child while he remains in the hospital. Such competence is necessary in order for positive and appropriate parental-infant interactions to develop. A hospital-based child development specialist, parent educator or nurse can assist the adolescent parent in this area by visiting the parent, if possible, during her hospital stay. At that time, one should try to establish a rapport with the young mother by allowing her to honestly share

her feelings, concerns and problems. The adolescent should be followed closely after discharge with frequent home visits and phone calls. The young mother should be encouraged to visit her baby regularly and often.

The nursing staff and other involved personnel should serve as role models for the adolescent parent by demonstrating appropriate behaviors. As a result of observing the behavior of other individuals who interact with her baby, the adolescent mother will learn new responses and behaviors, resulting in greater comfort and confidence in interacting with her infant. It is hoped that greater confidence will lead to more normalized mother-infant relationships.

It is important to try to get the adolescent parent involved in her baby's development, stressing to her the values of appropriate stimulation and positive interactions in order to facilitate her infant's development. The adolescent mother should also be made aware that the nurses are often so busy administering necessary nursing care that they are unable to give individual babies the time needed for appropriate stimulation. Therefore, it is crucial that the teen parent visit her baby often in order to provide the infant with the stimulation he needs.

It has been reported that once the young parent begins to invest time in the hospital nursery with her high risk infant, and has gotten positive feedback from nurses, staff and her baby about her interactions, the following will occur:[16]

1. Parental visits will increase.
2. Fathers involvement will increase.
3. Knowledge of child development gained from the experience will foster long-term and positive parenting.

4. Parents will pay more attention to the infant's behaviors and will respond to their needs.
5. Perception of the infant will change.
6. Interaction with the infant will change.

Although serious medical conditions can be a major barrier to positive maternal-infant interactions for adolescents, there are several other factors which should not be overlooked when working with this population. Some of the other barriers which prevent successful interactions between adolescent parents and their children are delineated below:[14,17,18]

1. Limited knowledge of child development and child rearing strategies
2. Unrealistic expectations
3. Inconsistent behavior
4. Lack of support from family and friends (may trigger child abuse)
5. Poor self-concept
6. Unmet personal needs
7. Inability to set limits for own behavior and the behavior of their children
8. Inability to provide empathetic care
9. Punitive child rearing attitudes
10. Feelings of guilt and shame

In order to help adolescents overcome these barriers it is essential for professionals to assist these young inexperienced parents in obtaining the skills they need in order to facilitate the development of their infants. Some of the skills teens need in order to become effective parents include:

1. Patience
2. Consistency
3. Ability to delay gratification
4. Good self-concept
5. Ability to be nurturing
6. Understanding of the needs and abilities of children
7. Ability to relate to her child
8. Ability to verbally interact with their children
9. Ability to provide daily routine care of their infants
10. Knowledge of proper nutrition
11. Ability to play purposefully with their child

One of the most important steps in trying to assist the adolescent parent in gaining the skills needed to facilitate the growth and development of her infant is to elicit her investment in her child. As the young parent becomes increasingly interested in her baby as a person, she will become the child's advocate which subsequently will make her more available to accept and seek information, ideas and support from others in order to enhance her skills as a parent and her ability to care for her child.

Adolescent-Infant Development:

A Comprehensive Service Delivery Model

The underlying premise behind the concept of adolescent-infant development is that if the adverse effects of teenage pregnancy are to be minimized, then a comprehensive services model, which fosters both the development of the adolescent and her offspring, must be instituted. To try to ensure that the adolescent gets prenatal care and maintains an uncomplicated pregnancy and delivery is not enough. Giving the adolescent parent a quick course in parenting skills and assessing the infant, confirming that he is a relatively healthy, normal child is not enough to ensure that both the adolescent parent and her infant will continue on an appropriate course of development. McArney describes the adolescent parent and her infant as a vulnerable dyad.[19] Unfortunately, many programs which seek to help this population terminate their services when the vulnerable dyad needs it the most--after the baby is born and the novelty of having a cute, cuddly baby wears off and the adolescent no longer is getting the attention that the pregnancy gave her.

The Adolescent-Infant Development program (A.I.D.) at Howard University Hospital is designed to provide comprehensive services for the pregnant adolescent/adolescent parent, her infant and her extended family. An important feature of the program is that intervention begins prenatally whenever possible and follow-up of varying degrees (depending on the individual needs of clients) extends over a three year period after the birth of the baby. A major aim of the program is to facilitate the development of the adolescent by (1), assisting them in continuing their education, (2), encouraging self-sufficiency and independence and (3), discouraging additional pregnancies during adolescence. The program also seeks to facilitate the development of the adolescent's offspring. This is done by providing the adolescent with

understanding of child development and parenting skills, providing developmental intervention to the infant and modeling appropriate behavioral patterns for the young mother. Another important aspect of the program is assisting the family of the adolescent in adjusting to the teen's new role as a parent, and her new role in the life of her offspring.

In order to meet the needs of pregnant adolescents and their offspring, A.I.D. offers the following types of services to its clients:

1. Counseling with adolescents and her parents
2. Home visits
3. Acting as a liaison/advocate with the school system, hospital and other agencies.
4. Neonatal assessment
5. Parent training
6. Individualized intervention plans for the infant
7. Teen forums
8. Individualized intervention plans for the parent
9. Assessment of parent needs
10. Referral and placement assistance
11. Infant stimulation/intervention in the hospital and home-based
12. Information and materials on special interest topics

The need for such a comprehensive family-centered approach when working with the pregnant adolescent population will be illustrated in the following case studies of two clients served by Howard University's adolescent-Infant Development program.

Case Studies

Nancy

> "In dealing with a young adolescent population, teaching the mother is only a part of the battle. Often the grandmother or, in many instrances, the great-grandmother, will be the mother's primary support system in caring for the infants."[20]

Such was the case with Nancy, a 16 year old black famale in the 11th grade when she was referred to A.I.D. by a collaborative community health facility. At the time of referral, Nancy was seven months pregnant and had herpes and gonorrhea. Nancy was living with her great aunt and attending a local high school. Nancy wanted to abort the pregnancy but her great aunt influenced her to carry the pregnancy to term. As a result, Nancy was ambivalent about the birth of her child throughout the pregnancy.

One month prior to delivery, Nancy was hospitalized for four days due to abdominal pains and bleeding. Approximately one month later, Nancy delivered a 7 pound baby boy born via primary C-section secondary to active herpes, gonorrhea and vaginitis. At delivery, the infant was blue, had poor tone, no reflexes and Apgar scores of 2 at one minute and 5 at five minutes (maximum score is 10). Charles, Nancy's infant, was placed in isolation for observation to determine whether he was going to develop herpes. Fortunately, he did not. However, it was noted on day 2 that Charles' left eye would not open and was later diagnosed as ptosis of the eye (commonly called lazy eye). At age two months, Charles was rehospitalized for problems with breathing and fever. He was then diagnosed as having seizures and was placed on phenobarbitol.

Nancy is currently back in school and plans to graduate at the end of the school year. Initially, her great aunt took care of Charles but she

found it too confining. Now, he is enrolled in the day care center located in the high school that Nancy attends. Presently, both mother and child are doing quite well even though initial adjustment of Nancy, her great aunt and Charles was a difficult process.

Initial contact with Nancy by A.I.D. staff took place at the referring agency where she was interviewed and screened for eligibility for the program. Due to Nancy's compromised health status and her willingness to participate in program activities, she was accepted into the program. Staff found Nancy to be very open although she exhibited little understanding of the bodily changes taking place as a result of the pregnancy and had no idea of what to expect during delivery.

Services provided to Nancy during the prenatal period included one home visit, many phone contacts and hospital-based meetings which were coordinated with her clinic appointments. The major focus of these contacts were to explain the growth process during pregnancy, prepare Nancy for her upcoming delivery, reinforce appropriate prenatal care (especially good nutrition), to clarify medical terminology and concerns which she may not have fully understood and to provide general support to Nancy and to her great aunt.

The program's social worker also assisted Nancy by working collaboratively with her high school in order to get her a tutor during her absence, ensuring that she would be able to keep up with her school work. Nancy had expressed concern about whether she would pass the 11th grade.

After Charles was born, it was important for staff to work closely with Nancy to help her fully understand why her child was placed in isolation and the procedures she had to use in caring for him. Once Nancy and Charles returned home there was a lot of conflict between Nancy and her aunt concerning roles and responsibilities for caring for Charles (i.e. baby's feeding and

sleeping schedule, what he should eat, etc.). Nancy also had difficulty adjusting to her new role as a mother and its effects on her relationship and activities with her friends. The social worker and child development specialist worked with both Nancy and her aunt--together and individually.

It was obvious to staff that Nancy and her aunt had genuine love and concern for each other, but that new roles which had emerged for them with the birth of Charles were significantly affecting their relationship. With time, support and understanding, they were able to resolve some of their conflicts and come to terms with their new roles.

Additional services which A.I.D. staff provided to Nancy and her family included counseling her about continuing her education through high school vs. a G.E.D. program, and the pros and cons of working part-time while in school and trying to care for her baby. Staff also worked with Nancy in assessing the developmental level of Charles and instructing her how to appropriately care for his needs.

A.I.D. staff has worked with Nancy and her family intensively for ten months and now that her situation has stabilized, she no longer needs intensive services. However, Nancy will be monitored cloesely by A.I.D. staff so that if her situation changes, she will know that A.I.D. is still available to assist her in coping with any future problems which may arise.

Pam

> "...a high risk situation which threatens any one member of the family will affect all its members. In the high risk family, the ability of the family members to function appropriately within the family unit and the ability of the family unit as a whole to maintain its normal function are threatened."[6]

Pam's case is one where each member of this usually very supportive and stable family was going through their own personal crisis at the same time and individually and collectively, their existence was threatened.

At the time of referral, Pam was 18 years old and was a month away from graduating from high school and was about 2 months pregnant. Pam lived with her mother and older sister. She had been dating the baby's father for some time and they had a very positive and stable relationship. Being in late adolescence and having almost completed her high school education successfully, Pam was quite mature and had some direction for her life. However, the socio-economic conditions of her family, coupled with the emotional strain that accompanied their problems put her at great risk.

Pam's sister had just had a miscarriage and both she and her mother had just been laid off from work. There was no income coming into the family and Pam had no way of paying for her prenatal care or delivery. The picture looked very bleak for them all. However, when the Adolescent-Infant Development program accepted Pam as a client, services were extended to the whole family. The program's social worker aggressively tackled the case by helping Pam to cut through the red tape she had been experiencing while trying to obtain Medicaid and assisted her mother and sister in their job hunting efforts. Throughout the time A.I.D. staff provided a lot of supportive counseling to the family.

After graduation Pam managed to secure a temporary job. However, towards the end of her pregnancy, she began to become frustrated and depressed because the doctors had miscalculated her delivery date and she no longer had a job. During this time she needed a lot of support and encouragement. Therefore, staff kept in contact with her on a weekly basis.

After 42 weeks, Pam delivered a 7 pound girl via C-section. Labor was

very long and hard and was a negative experience for Pam. Despite Pam's maturity for her age, the reality of motherhood created a lot of anxiety and insecurity in her. During regular visits while Pam was in the hospital, staff was supportive and let her vent her fears and concerns and gave her tips on how to handle certain situations in order to build her self-confidence.

Once home, Pam adjusted quite well to her new role. She was able to return to the job she had held before the birth of her baby on a permanent basis and she was able to make arrangements with a neighbor to babysit while she worked. Pam's boyfriend is in a training program at a local university and he and his family are providing financial support for the baby. Pam will also be beginning a training program for word processing in the spring.

While Pam was getting herself back on her feet, so was the rest of her family. Her mother had gotten a full-time job and her sister had entered a training program to become a medical secretary.

In this situation, it would not have been enough for staff to work only with the pregnant adolescent. The extreme stress of Pam's other family mem-mers could not help but spill over to Pam. Therefore, it was necessary to use a family-centered approach in every sense of the word and to help this whole family to resume normal functioning. By doing this, A.I.D. helped Pam and her family to maintain a positive environment in which this young mother and her child could continue to grow and develop.

Summary

Teenage pregnancy is a major problem in this country which not only adversely impacts upon the adolescent, her offspring and her family, but also society as a whole. If professionals truly seek to help this population, then a comprehensive approach which breaks the vicious cycle of children having children must be utilized. What is needed is an approach which ceases to perpetuate the need for Aid to Dependent Children and one which facilitates the education of adolescent parents and discourages additional pregnancies until later adult life.

One model of service delivery which attempts to provide a comprehensive approach to the teen pregnancy problem is the Adolescent-Infant Development program at Howard University. This program uses a family-centered approach which emphasizes the development of both adolescent and infant and realizes the extreme value of the extended family in providing support for this vulnerable dyad. Some of the most salient features of this program are that:

1. It provides a comprehensive, holistic approach to working with adolescents and their offspring.
2. It fosters the individual development of the pregnant adolescent.
3. It provides support for the family.
4. It assists the adolescent in clarifying feelings, roles and responsibilities.
5. It assists adolescents in continuing education or securing vocational training.
6. It facilitates appropriate development of the infant.
7. It increases adolescents' understanding of child development and infant needs.
8. It assists in preventing child abuse by giving them an external

support system where they can get help and additional resources if needed.

There are many adolescent pregnancy programs in existence today. However, there are few which seek to address the problem by facilitating the development of the adolescent parent and her infant through a comprehensive, holistic, family-centered approach. The Adolescent-Infant Development Program at Howard University is one program which seeks to accomplish this task.

References

1. Alan Guttmacher Institute. Teenage Pregnancy: The Problem that Hasn't Gone Away. Alan Guttmacher Institute, 1981.

2. Donley, J. and Lynch, P. "Teenage Mother...High Risk Baby". Nursing. May 1981.

3. President's Committee on Mental Retardation. Mental Retardation: Prevention Strategies that Work. U.S. Government Printing Office. Washington, D.C. 1980.

4. Cram-Elsberry, Charlotte and Malley-Corrinet, Anne. "The Adolescent Parent" in High Risk Parenting by Suzanne Hall Johnson. Philadelphia: J.B. Lippincott Co., 1979.

5. Anastasiow, Nicholas J. The Adolescent Parent. Baltimore: Paul H. Brookes, 1982.

6. Johnson, S. H. High Risk Parenting: Nursing Assessment and Strategies for the Family at Risk. Philadelphia: J.B. Lippincott Co., 1979.

7. Fischman, S. "Delivery or Abortion in Inner-city Adolescents." American Journal of Orthopsychiatry 47(1). 1977.

8. Mott Foundation. Teenage Pregnancy: A Critical Family Issue. Mott Foundation Annual Report, 1981.

9. Ladner, J. "Adolescent Pregnancy--A National Problem." New Directions January 1985.

10. Irwin, C. "Growth and Devevelopment: Psychosocial Aspects." In Compendium of Resource Materials on Adolescent Health. U.S. Dept. of Human Services, Rockville, MD. 1981.

11. Sherline, D. "When the Mother is a Child Herself." Contemporary OB/GYN, December 1984.

12. Cobliner, W. Godfrey. "Prevention of Adolescent Pregnancy: A Developmental Perspective." In Pregnancy and Childbearing During Adolescence--Research Priorities for the 1980's. Ed. Elizabeth R. McArney and Gabriel Stickle. New York: Alan Liss, Inc. 1981.

13. Alan Guttmacher Institute. 11 Millian Teenagers--What Can be Done About about the Epidemic of Adolescent Pregnancies in the United States? New York: Alan Guttmacher Institute, 1976.

14. Spivack, F. "At-Definite-Risk Infants and their Adolescent Mothers." In The At-Risk Infant--Psycho/Socio/Medical Aspects. Edited by Shaul Harel and Nicholas J. Anastasiow. Baltimore: Paul H. Brooks Publishing Co., 1985.

15. Brown, J.V. and Hepler, P. "Nursery Based Intervention." Journal of Pediatrics. September, 1980.

16. Duerr, Ellyn in Infant Stimulation with a High Risk Acute Care Infant, Seminar # 2. by Susan M. Ludington-Hoe. Los Angeles, 1982.

17. Scheurer, S. "Child Abuse and Neglect by Adolescent Parents." In Pregnancy and Childbearing During Adolescence--Research Priorities for the 1980's. Ed. Elizabeth R. McArney and Gabriel Stickle. New York: Alan Liss, Inc., 1981.

18. Jarret, G. E. "Childbearing Patterns of Young Mothers: Expectations, Knowledge and Practices." MCN 2(7): 112-124.

19. Turner, E. "Improving Parenting Practices Among Adolescents." MCN 2(7): 122.

20. McAnarney, E. "The Vulnerable Dyad--Adolescent Mothers and their Infants." In Minimizing High-Risk Parenting. Ed. Valerie Sasserath. New Jersey: Johnson and Johnson Baby Products, 1980.

Table I

Status of Families of Adolescents who Aborted Compared to Those who Delivered

Adolescents who Decided to Abort	Adolescents who Decided to Deliver
1. Came from families of higher socio-economic status (i.e. Families tended to be self-supporting; only 28% were on welfare.)	1. 44% of families of adolescents who delivered received welfare. Family felt that having another child in the household wouldn't make a difference.
2. Mothers of aborters were better educated. Average grade completed was 11.1.	2. Mothers of deliverers were less educated--average grade completed was 10.2.
3. Employed women in aborters homes had higher paying jobs.	3. Employed women in the home had lower-paying jobs such as factory worker, cleaning woman and waitress.
4. Adolescent aborters had higher educational level than deliverers.	4. Many deliverers had already dropped out of school by the time they became pregnant. Education was not a priority in their lives.
5. Half of the fathers of aborters were absent from the home--one out of every four was said to be deceased.	5. Half of the fathers were absent from home but most were living elsewhere--only one out of every eight were said to be deceased.

a) Information extracted from Susan Fischman, "Delivery or Abortion in Inner City Adolescents", Am. Journal of Orthopsychiatry, 47 (1), January 1977

Table 2

Familial Influences on Adolescent Pregnancy and Parenthood

Carrying Pregnancy to Term	Continuing Education
If the adolescent feels that her family is supportive and will accept her decision to have her child, the greater the chance she will carry the pregnancy to term.	If the family of the adolescent will help with child care responsibilities, the adolescent is much more likely to continue her education. If family doesn't share the child care responsibilities, the girl will probably drop out if she hasn't already and will probably go on welfare.
Future Professional Opportunity	**Marriage**
Without familial support, education will be truncated. Therefore, professional opportunities will be diminished due to lessened employability.	If the family encourages early adolescent marriage as a result of pregnancy, there is a greater chance that the marriage will be short-lived due to limited education and poor financial prospects.
Acceptance of the Role of Parent	**Child Rearing Practices**
If the adolescent's parents assume the primary role for caring for the child then the adolescent may relinquish her parenting responsibilities. However, if the parents make the adolescent responsible for caring for the child, and assists her in the process, the adolescent will assume greater parenting responsibilities for her child.	If the adolescent lives at home with her parents they will probably provide a role model for how her child should be raised. These methods will probably be adopted by the adolescent parent. Without support and guidance, the adolescent parent may easily be frustrated by her unrealistic expectations of her child's behavior. This frustration may lead to child abuse. Generally, adolescent parent child abuse is eliminated when the adolescent lives with her family. Also, the cognitive development of the infant is better if the grandparents are involved in child rearing practices.
Fertility	
If adolescent pregnancy and delivery are accepted by the family, then there is greater chance of repeat pregnancies, especially if the adolescent parent is not encouraged or given the opportunity to continue her education. On the other hand, frequent abortions may lead to problems of infertility at a later stage when pregnancy may be desirable.	

BEST COPY AVAILABLE

Table 3

Impact of Living with Family on Teenage Mothers' Future Development

Area of Impact	Percentage of Adolescents Living with Parents	Percentage of Adolescents Living Alone
Remaining in School	87%	76%
Graduating from High School	62%	47%
Holding Jobs	60%	41%
Receiving Welfare	43%	65%

a) Information abstracted from the Mott Foundation special report "Teenage Pregnancy: A Critical Family Issue," 1981

BEST COPY AVAILABLE

Table 4

The Developmental Process During the Three Stages of Adolescence

Early Adolescence: Females, 10-13 years Males, 12-14 years	II. Middle Adolescence: Females, 13-16 Males, 14-17	III. Late Adolescence: Females, 16-20 Males, 17-21
The major characteristics of this stage are puberty and the struggle of beginning to separate from one's family. More specifically, the adolescent begins to leave the family system and concentrate on peer relationships. With the onset of puberty, adolescents become concerned with their developing bodies. The adolescent will compare his/her own normalcy with peers of the same sex. And lastly, the adolescent will explore new-found ability to attract.	In middle adolescence, there is now a decreased preoccupation with a less rapidly changing body. This then permits the adolescent to explore and develop intense involvement with peers. The peer group provides the emotional security for the adolescent in his/her separation from the parents. In addition, some other focal areas are the adolescent's major conflict over independence; the adolescent explores the ability to attract the opposite sex. It is at this point that sexual behavior and experimentation may begin. The peer group sets the behavioral standards for the adolescent. The adolescent also enjoys intellectual powers which are idealistic and altruistic, not to mention their rich fantasy life.	Previous experience with peer relationships now enables adolescents to apply their social skills in attempting to master his/her environment and shaping his/her future. Parents are now (or should be) giving the young person more responsibilities and society is increasing its demands on them. It can be said that this stage is characterized by the defining of life goals, sexuality and intimacy. At this point, emancipation is nearly secured; the body image and gender role definition is nearly secured. Relationships are now at the point where there is a process of sharing and giving and functional roles begin to be defined.

a) Information extracted from Charles Irwin, "Growth and Development: Psychosocial Aspects," University of California Adolescent Program, 1981

BEST COPY AVAILABLE